July 18, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0644-01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a physician who is Board Certified in Neurology and Pain Management.

THE PHYSICIAN REVIEWER OF THIS CASE AGREES WITH THE DETERMINATION OF THE INSURANCE CARRIER. THE PATIENT'S REFERRAL TO A CHRONIC PAIN PROGRAM SESSIONS IS MEDICALLY NOT NECESSARY.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of

Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on January 8, 2003.

Sincerely,

MEDICAL CASE REVIEW

This is for___, ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0644-01, in the area of Neurology/Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution request.
2. Appeal letter from___, dated March 27, 2002.
3. Independent Medical Examination by ___.
4. Several notes from ___.
5. Psychological evaluation from ___, dated 2/22/02.
6. Neurosurgical consultation, dated 7/30/01.
7. Several notes from ___.
8. CT myelogram of the cervical spine, report dated 11/14/01.
9. MRI of the cervical spine, report dated 4/03/01.

B. BRIEF CLINICAL HISTORY:

This is already well documented in the multiple notes that were reviewed, with the date of injury reportedly on ___, with a work-related injury involving a car-lift, in which the patient had the onset of neck and right shoulder pain. The patient has undergone multiple evaluations including imaging studies and treatment including some "physical therapy," which may have been primarily passive in nature (according to the Independent Medical Examination note by ___, but no specific physical therapy notes were available for my review). He has also undergone some epidural steroid injections and various other treatment modalities including medications such as Vioxx, Ultram, Robaxin, ibuprofen, Elavil, etc. Other treatment trials have included a TENS unit, massage therapy, etc.

C. DISPUTED SERVICES:

The services that are in question include a referral to a chronic pain program, thirty (30) sessions.

D. DECISION:

I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

In general, I agree with the reasoning outlined by ___ on his Independent Medical Examination earlier this year. There is no convincing evidence from the medical records available that an adequate amount of physical therapy has been tried on an outpatient basis, with an emphasis on active exercises aimed at strengthening and conditioning the involved musculature of the cervical spine and shoulder girdle. Likewise, there did not appear to be any documentation in the medical records provided to implicate any treatment attempts at outpatient psychotherapy. I think it would be reasonable to attempt these treatment modalities in an appropriate and adequate manner prior to considering a more extensive chronic pain program, as requested.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such

information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

_____

Date: 12 July 2002